OFFICIAL REPORT
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DRAFT

Health, Social Care and Sport Committee

Tuesday 10 March 2026

Session 6

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Tuesday 10 March 2026

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
XXth Meeting 2026, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Joe FitzPatrick (Dundee City West) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Councillor Nairn Angus-McDonald (Public Health Scotland)
Councillor Julie Bell (Public Health Scotland)
Alastair Boyle (Public Health Scotland)
Paul Johnston (Public Health Scotland)
Jenni Minto (Minister for Public Health and Women's Health)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 10 March 2026

[The Convener opened the meeting at 09:15]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 11th meeting in 2026 of the Health, Social Care and Sport Committee. I have received apologies for today's meeting from Paul Sweeney.

Our first agenda item is to decide whether to take agenda items 4, 5 and 6 in private. Do members agree to take those items in private?

Members *indicated agreement*.

Public Health Scotland

The Convener: Our second item is an evidence session with representatives from Public Health Scotland. I welcome to the committee Councillor Nairn Angus-McDonald, who is a non-executive director; Councillor Julie Bell, who is also a non-executive director; Alastair Boyle MBE, the board chair; and Paul Johnston, the chief executive officer.

We will move straight to questions.

David Torrance (Kirkcaldy) (SNP): Good morning, everyone. What is the status of the public health priorities that were published in 2018, and what progress has been made against them?

Paul Johnston (Public Health Scotland): Thank you for the opportunity to give evidence this morning. I am delighted to be here.

The public health priorities were developed as part of the public health reform programme that led to the establishment of Public Health Scotland. You will recall that Public Health Scotland was established on 1 April 2020. Those reform priorities drove our work in the early years, and they have now been subsumed by the population health framework.

If we want a definitive statement of Scotland's public health priorities, we should look to the population health framework. It was developed by the Scottish Government and the Convention of Scottish Local Authorities, with substantial input from the national health service and the third sector, and it sets out a broad range of priorities.

There is a great deal of similarity between the priorities that were developed in 2018 to 2019 and those in the population health framework, but the latter is somewhat broader, reflecting the developing evidence on what needs to be done. For example, the population health framework contains more on the need to consider climate and health, which was not included in the earlier framework document. It is also recognises the important role of the national health service. Alongside improving health, it is essential that we address the wider determinants of health.

David Torrance: Is there a gap between evidence and practice in public health? Do we lack evidence to help practice?

Paul Johnston: Scotland's has fantastic evidence about what needs to be done to improve the health of the nation, but that evidence can always be developed further. Public Health Scotland has a range of doctors, other clinicians, scientists and researchers who are developing that. We also work in partnership with universities in Scotland and beyond.

Our main issue is not that we need evidence, but that we must turn that evidence into action. The Scottish Parliament, the Scottish Government, local government and NHS boards have an important role to play in that regard. It is about turning evidence into action.

Alastair Boyle (Public Health Scotland): I will add to that. First, we are very grateful to be here. We are also quite excited, as this it is the first time that Public Health Scotland, as an organisation, has been called to give evidence.

Paul Johnston is exactly right that the evidence is there. There is also something in how we present it for public scrutiny. We pride ourselves on the trusted statistics that we produce on waiting times and all the rest of it. We also lead the Scottish Population Health Observatory, through which we capture and share an awful lot of statistics and figures.

The challenge that we have put to the organisation is to look not only at how the system is working but at how the system works with regard to diversion. We need to consider how the pharmacy first programme operates in a way that diverts people away from the front door of our NHS and how the frailty pathways work to divert people. We know from the Scottish Ambulance Service that up to 60 per cent of its calls do not result in someone being transported. We need to find a way of presenting all of that, and then consider how we identify the metrics and develop a way of reporting figures on prevention, and how that in turn should shift the way in which we present figures on performance.

If the population health framework is about making prevention an operating model, we should have a set of metrics to support that. As an organisation, we now need to look at the statistics that we have and the information we gather, identify where the gaps are, and then consider how we can present that in a way that makes it easier for the public and others to see how we are shifting towards prevention.

David Torrance: I have no further questions, convener.

Emma Harper (South Scotland) (SNP): We have heard at committee that five-year-olds in the United Kingdom are up to 7cm shorter than their counterparts in Europe, although that evidence is being contested. Danny Dorling and Tim Cole wrote a paper about how Covid affected that and the collection of some of that data. It has been suggested that austerity is a cause of children in the UK being up to 7cm shorter, but issues such as obesity and childhood obesity are also relevant, and there are papers that contest that information as well. What is the latest on that?

Paul Johnston: I am afraid that I do not have the specific details—I cannot tell you how our evidence sits alongside what you have just said about the height of children. I do not want to suggest that I have evidence in front of me on that particular issue.

However, we are clear that poverty and inequality have a huge impact on health, which would chime with your comment about the height of children. We are also clear that, if we take the headline measure of life expectancy in Scotland, we have seen it stall and then decline in 2010, 2015 and through to 2020. The expertise that we have points to rising rates of poverty as being central to that reduction in life expectancy, together with the impact of the Covid-19 pandemic.

We have seen a recent and welcome increase in life expectancy in the most recent National Records of Scotland figures, so we hope that we are seeing the tide start to turn on some of the key measures and metrics around Scotland's health. However, in recent weeks, the NRS has published statistics on healthy life expectancy, which, I am sad to say, show a continued deterioration. I know that those are broader figures, but it is important to look at the whole picture, and we often see data on, for example, children, young people and other health measures following that overarching trend.

The recent publication on healthy life expectancy shows that there is a real risk that more people will live a greater proportion of their lives in ill health, and that must be a driver for determined action.

We produce data and information about the wellbeing of children and young people. As I say, I am happy to follow up on the specifics of the evidence on the height of children.

Emma Harper: Height is only one measurement, is it not?

Paul Johnston: Yes, exactly.

Alastair Boyle: We will absolutely get back to you on that. Our organisation is very grounded in the why. I remember young children coming to Scottish Fire and Rescue Service events who had never seen a banana before. There are still some challenges around that. We know that some areas are healthy food deserts and that it is difficult for people either to get healthy food or to purchase it. A lot of support is needed on that issue.

Having looked at the figures, we know that getting people to a healthy weight is a quick win that can make a big difference to their lives. The cost of obesity to the NHS in Scotland is about £775 million a year and the missed opportunity cost to people is about £4.5 billion. We know that, whether someone is underweight or overweight, it is important that they get the right nutrition, so we

are very focused on that. We will get back to you with some of the detail.

Emma Harper: The good food nation plan will work alongside the climate change plan, the population health framework and everything else in order to address what we need to do, which is to tackle obesity in Scotland.

Paul Johnston: We are working closely with others to support the implementation of the good food nation plan. We absolutely agree that the Scottish Food Commission has an important role to play and that the NHS and other public bodies need to prepare their good food nation plans. We want public bodies to act as exemplars by providing healthy food to those who use their services, and there is an opportunity to go further.

It is really clear, based on the evidence and not on opinion, that we need to improve Scotland's food environment in order to tackle the levels of overweight and obesity. Actions are already under way, but there is more that can be done. We may get an opportunity to say more about that during this meeting.

The Convener: On the theme of national strategy and public health priorities, I note that priority 3 in the "Public Health Priorities for Scotland" is to have a

"Scotland where we have good mental wellbeing".

However, when I look at the strategy document, I can see only one reference to mental illness or mental ill health. How will you promote the mental wellbeing of Scotland's population if you do not refer to that in your priority document?

Paul Johnston: We do recognise the importance of mental wellbeing. In our Public Health Scotland strategy, which was published in the past few weeks, we set out a vision for Scotland over the next 10 years that expressly includes people flourishing in both their physical and mental wellbeing. We absolutely recognise the importance of that.

I can also confirm that we have a programme of work under way within Public Health Scotland that focuses on mental health and mental wellbeing. For example, there is specific work on reducing suicide rates in Scotland and a range of work to support mental wellbeing in the early years. We can provide much more information about that, but I absolutely recognise that we need to focus on both physical and mental wellbeing.

The Convener: Do you recognise that there is a difference between mental wellbeing and mental ill health?

Paul Johnston: Yes, absolutely. We also speak about the importance of connection and of a sense of purpose, which takes us into the importance of communities where individuals can thrive. We absolutely recognise that good mental wellbeing is a foundation for good health.

The Convener: I place on record my entry in the register of members' interests, which says that I hold a bank nurse contract with NHS Greater Glasgow and Clyde and that I am a registered mental health nurse.

We move to questions from Elena Whitham.

Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP): Paul Johnston, you have already touched on the theme that I will cover, which concerns the ways in which persistent health inequalities can stall life expectancy. In addition to that, we know that people in Scotland's poorest neighbourhoods are almost five times more likely to die from preventable conditions compared with those in the least deprived, and that, as you have alluded to, they live for 25 fewer years in good health, which has a huge impact on overall wellbeing.

You have touched on a couple of the drivers, but what are the key factors behind stalling life expectancy? I found a wee glimmer of hope in the latest figures that we have seen, but what factors are driving widening health inequalities in Scotland?

Paul Johnston: I am happy to start and am sure that colleagues will want to say more.

That is absolutely at the heart of what Public Health Scotland wants to address. Pretty much every time I have an opportunity to speak on behalf of the organisation, I begin with the fact that adults in the poorest parts of Scotland have a healthy life expectancy that sits somewhere in their 40s, whereas adults in the wealthiest parts have a healthy life expectancy that sits somewhere in their 60s.

That represents a huge gap, but it is not inevitable. There is clear evidence that good-quality health and social care services have a role to play. Experts differ slightly on that, but we are probably talking about 20 per cent of what makes for health and wellbeing being attributable to access to high-quality health and social care services. The biggest contributor is the social and economic conditions in which people are born, live and work.

09:30

Through whichever frame you look—whether the population health framework or the public health priorities that we have referred to—you will see the absolutely central importance of tackling poverty, of children having a good start in life and of high-quality, flexible employment. Those factors

need to be addressed in order to improve Scotland's health and tackle Scotland's health inequalities.

The next large area concerns what might be described as healthy living. That relates to the relationship that we have with drugs, alcohol, tobacco, food and physical activity. One thing that I learned from working in that area of public health is that it is never about just one thing—that is part of the challenge. We need to consider not one thing but the range of factors that influence health and wellbeing, and ensure that action is taken across that range.

Work is under way across that range. We are particularly keen to ensure that the Scottish Parliament in the next session takes action across that range and that it sustains that action. There is huge potential for improvement if we do that.

Alastair Boyle: In a second, I will bring in board colleagues who are representatives of the Convention of Scottish Local Authorities.

As a board, that is exactly where we are: we say that there is no magic bullet. I have spent my life working on prevention, and I know that it can feel invisible; however, when it is missing, its absence is absolutely felt. The challenge is that that is like the dog that did not bark: it makes it difficult to work out which particular bit of prevention was successful.

We need to have a broad range of focused activities. We have tried to operationalise that by feeding into our strategy the population health framework, the renewal process and public sector reform. The ask of the board is that the strategy is turned into an action plan over the next 10 years—that it is broken into chunks and that we, as a board, can see that the organisation is absolutely focused on delivery.

As was the case in my previous life, and as Paul Johnston has described, the levers of influence lie not within the NHS but elsewhere. That is where we have the advantage of being co-sponsored by COSLA, because those levers lie in a combination of local and national Government. Julie Bell is well placed to talk about how we will push that work on and help our COSLA colleagues.

Councillor Julie Bell (Public Health Scotland): The question speaks to the sense and opportunity in that co-sponsorship arrangement with COSLA. Much of the delivery will be down to local authorities, community planning partnerships and health and social care partnerships. The third sector is also critical, as is the role of unpaid carers, for example.

However, when it comes to what is happening in local authorities on investing in children's early years, opportunities for families that might be struggling to learn to play with their children, investing in mental health support within schools for children and addressing the increase in the numbers of children who struggle to attend school, I think that most local authorities are still experiencing the fallout from the pandemic.

Local authorities also have a massive role to play when it comes to dealing with such levels of anxiety—perhaps depression—and mental ill health, and supporting children and young people on a different pathway, to get them into further or higher education or apprentice opportunities.

Housing, too, is a public health issue. I am a councillor in Angus, and I am very aware of the work that we have done in the Tayside collaborative and integrated children's services, which has identified a slight increase in childhood respiratory ill health because of damp housing. That is a concern. We can see the impact that housing has on children's health—and, obviously, on the mental health of their parents, if they are struggling.

It is therefore critical that local authorities get on board with those strategic documents, that they are really integrated and that they walk alongside us to deliver on their priorities. We all want the same things: for people to live happy, healthy, thriving lives. No part of the system will be able to do that on its own. We can work together on that—it is a joint mission.

I know from working in my area that the expertise that our public health colleagues bring to this work is priceless, because prevention and early intervention are famously challenging to quantify. This is a long-term initiative, which is why our strategic documents look forward 10 years and beyond. Through Public Health Scotland, we are providing the expertise to produce the data and the evidence that show that, yes, it is worth doing and that we need to keep doing it. Although it might take a while to deliver the outcomes that we need, we are on the right trajectory.

Elena Whitham: That leads me to the next question, which I was already starting to formulate. We understand that we can directly link stalling life expectancy and the widening of health inequalities to the decision making that happened in relation to austerity. Julie Bell spoke to this issue when she mentioned getting alongside one another. As we go into a period of public sector and services resource pressures, how do we work together to ensure that the decisions on national or local priorities that are taken at this point in time do not start to widen health inequalities again? How do we ensure that decisions are really taken in people's best interests and not guided by resourcing only?

Alastair Boyle: I will bring in Nairn Angus-McDonald in a second, but I think that that is exactly the challenge. That is where we are. Early on during Covid, there was an express endeavour to make people understand that a cost of living crisis is a health crisis. We would say to partners that the decisions that they were making would have a health impact that might be far worse not only for the budget but also for people. Healthy life expectancy is continuing to drop, but I am always struck by that figure of the 25-year gap between the richest and poorest. It is not just 25 years in total; it is 25 years longer simply because of where people live, and they are really vulnerable.

Part of our job is to put practical tools in the hands of people and to pull the people and the ideas together. Our collaboration for health equity in Scotland—CHES—work with Professor Sir Michael Marmot is starting to really look at not only how we can use the data to inform the current and future picture so that the decisions that are made support good health, but what practical things we can do that do not involve greater investment and will help us to keep that focus on healthy life expectancy. It is about starting to think about those underlying conditions, which Paul Johnston and others have described as being about thriving. That is where our co-sponsored nature, and the input and experience of people such as Nairn and Julie, are really valuable.

Councillor Nairn Angus-McDonald (Public Health Scotland): I am mindful that we are before a Scottish parliamentary committee with former ministers and shadow ministers, but I think that if we are to tackle Scotland's health inequalities, prevention and early intervention will come not from the national Parliament but from councils on the ground. It is important to get the councils to recognise that although it is easy to not spend on prevention and early intervention when you have other pressures—it is easy to say, "Well, we'll get to that"—you will recoup, multiple times, every pound that you put in now. There is that conversation.

The fact that we are COSLA-sponsored board members means that local government is not being directed to do something, and that we are part of the conversation, which is really helpful. In the CHES work in particular—I am a councillor in North Ayrshire, which is one of the CHES areas—Michael Marmot looks at health equity instead of health equality. It is about bringing everybody along to ensure that it is not that everybody gets the same but that people get what they need. That proportional universalism is exactly the kind of route that we should be going down.

Councils are not immune to budgetary pressures and stretched budgets. Ensuring that prevention and early intervention are still at the core of everything that councils do is how we will tackle the inequalities.

Elena Whitham: When resources are definitely tighter, the fact that we will not see the benefits until perhaps a decade later makes the argument difficult.

Paul Johnston said something earlier about zooming out and looking at what national Government, local government and our partners more widely can do versus putting all the onus on the individual. I think that that often ends up being our default position—we will just eat better, or just do this or just do that. However, we understand about food deserts and all of the issues that surround poverty and inequality. How do we ensure that that is where we keep our focus?

Paul Johnston: That is a great question, and it shows why evidence is so important. We must proceed on the basis of the clear evidence about what will work, and not on the basis of anecdote or even false information about what will work. We see it as crucial that we tackle false information where it occurs.

One of the most impressive bodies of evidence is from Professor Sir Michael Marmot. We invited him to come along and speak to us the first time that we managed to get Public Health Scotland colleagues together in person after the pandemic. It was very inspiring to hear about the lifetime of work that he has done as a leading public health expert with international recognition.

Michael Marmot developed eight areas of action for improving health. All of them recognise the need for individuals to be empowered but also the need for action at a system level, nationally and locally. What we found particularly inspiring about his framework is that it does not say that we can take action only when there is plenty of money in the system; it says that we can use money in a different, more targeted way so that those with the poorest health are supported.

As Nairn Angus-McDonald was saying, we are pleased to be working intensively in North Ayrshire, as well as in South Lanarkshire and Aberdeen, using the Marmot principles. There is no extra money, but we are finding out what it will look like for the local authority, the health board and the community planning partnership, using the principles, to look in detail at the data that we can provide from the Scottish Public Health Observatory and then agree on specific areas of action that will lead to improvements in health. That work is on the go right now—we were discussing it with colleagues in South Lanarkshire just yesterday—and we want to see it spread much more widely across Scotland in the period ahead.

That is local action, but national action is also vital. That is why we have written to all political parties in the Scottish Parliament, and we have shared with the committee our briefing, which sets out the range of further areas of action that, based on the evidence, we consider that the Parliament should prioritise in the next session. Those areas of action go across the domains of health.

Elena Whitham: Maybe we should be looking at the Marmot principles and the Christie principles together when we make any decisions across all public services. Thank you.

Brian Whittle (South Scotland) (Con): Good morning. I have been listening intently to what the witnesses have been saying. I am looking at prevention. After hearing about the causes of good healthy life expectancy and poor healthy life expectancy, I am going to go down my own route here. The two biggest indicators of healthy life expectancy are—by far—VO_2 max and muscle mass. They are way in advance of indicators such as those that measure smoking, drinking and obesity. Logically, that would say to me that we need to be physically active. Physical activity is a key driver in tackling poor healthy life expectancy. If you are physically active, you are less likely to smoke or drink, more likely to be cognisant of what a good diet is and more likely to have good mental health.

Prevention is, in essence, what we are talking about when we talk about improving the health of Scotland. Where are we in that effort? Where are we with using such statistics to drive our policy?

Alastair Boyle: I will let Paul Jonston answer on the technical aspects.

In preparing the document that Paul described—our policy briefing—we met with a number of political parties. We had the opportunity to meet with you and talk about sport, which we then thought very carefully about. Paul has had some really good meetings that have revealed practical examples, such as in the Scottish Borders. As a board, we are also thinking about that.

I have met the chair of sportscotland to discuss the wicked problems around inactivity in particular and the issue of the route to physical activity through sport—you will know about the benefits in terms of discipline and social cohesion that come along with involvement in sport. We are going to explore doing some joint board work around that. About 15 per cent of people are totally inactive. That is a wicked problem, as, apparently, that figure is not really changing. Jointly, the boards will take a public health approach to see whether there is something that we can do around that. There is a lot of other work going on in terms of policies and documents in relation to how we operationalise that approach. I will let Paul Johnston go into some of that detail.

09:45

Paul Johnston: It is good to be able to speak further about this issue. We absolutely agree that physical activity and the promotion of physical activity, of which sport is a part, is a crucial element of prevention. One of the key areas of prevention that we would focus on in terms of health is stopping smoking. We have to recognise that the data shows that tobacco is still the single biggest cause of preventable ill health. Alcohol, drugs and obesity are other key elements, but I agree that physical activity has a central role to play.

We have developed "Physical Activity for Health: Scotland's National Framework", working in partnership with the Scottish Government and COSLA. That is another example of joint sponsorship, where we play a role locally and nationally. The framework is now being adopted by quite a number of local authorities and health boards. It says that we need to see physical activity in all sorts of settings, including the workplace, so that we can ensure that our workplaces are not places where we are simply stationary for long periods. It also has a focus on physical activity within the national health service, and considers where we are in terms of the NHS building physical activity pathways into its work in order to prevent harm and the need for surgery, and to support rehabilitation. It also examines how we can ensure that local authorities are active in their partnerships around sport and physical activity as well as how we can promote physical activity in terms of transport to and from work. It is a holistic framework, drawing on very good, robust evidence from the World Health Organization and other places, and we are working to see that implemented. There is a lot more that we can do in that area.

It is worth saying that we also have the chief medical officer's guidelines on physical activity, and that we are working across the four nations, because there is a UK-wide dimension to this. We are looking at how we can ensure that those guidelines are really well understood. In particular, we want to draw out some of the evidence around the importance of strength and how even small amounts of physical activity are beneficial in the case of people who are not physically active at all. There is work that we want to do in that regard across the four nations.

Brian Whittle: I would just point out that I was instrumental in getting a gym put into this Parliament for the very reason that you mention. It is probably the only thing that I have achieved in my 10 years here.

On your point about people stopping smoking, it is more important to prevent them from starting in the first place. We also need to dump the metric around the number of people who are inactive, because, quite frankly, the situation is a lot worse than that. The minimum requirement to qualify as being active is getting out of bed and going to the fridge, basically.

On physical activity—to focus on that, rather than sport—one of the key battlegrounds in that regard is the educational environment. We have the opportunity to work with pre-school children during their 1,140 hours of free childcare and with school children from primary right through to secondary. That is an environment where we can have a huge impact. As well as doing all of the other key things that we are talking about, is that not where we should focus our efforts in terms of getting people to be physically active and influencing their diets? We can make a huge impact at that level. Should that not be where we are heading?

Paul Johnston: One area that I should have mentioned in relation to the physical activity for health framework that Public Health Scotland has developed is physical activity in childhood and in education settings. That is vitally important. I think that Julie Bell wants to say more on that.

Councillor Bell: Sportscotland's active schools programme is making significant impacts in schools. Young people are seeing sport as fun. The programme is about team building and working on good communication skills, as well as physical activity. It is way different than in my day, when it was pretty much torture, to be honest.

Brian Whittle: We have a different opinion on that.

Councillor Bell: Well, I think my ankles still have scars from hockey sticks.

It is definitely about community development hubs, where children and young people can access physical activity and sport outwith the school environment, and can continue in whichever discipline that they enjoy.

As with any health promotion or health improvement activity, it is about meeting people where they are on the change circle, if you like. It is about using things as simple and as inexpensive as health walks to support people out of isolation and loneliness and to improve their physical health. Maybe someone is dealing with sciatica or something and it allows them to work that out. They can reduce medication in a supported environment, working with their general practitioner and social prescribers. These are low-cost interventions that can have a significant impact on someone's physical and mental health and wellbeing and also work towards reducing prescribing budgets, which is a challenge for most areas.

As Paul Johnston has already said, it is never about one thing in isolation; it is a mixture. It is about creating that environment, with local authorities working on things such as food-growing strategies, for example, to connect children with where their food comes from, and trying to support families who are perhaps working but experiencing food insecurity and accessing low-cost or sometimes free food from local food hubs. It is about that kind of effort. It all comes through the community planning partnerships identifying a need and addressing it, and it is a mixture of statutory money and charitable money. It is absolutely critical that we look at the whole system. The school environment is a key example of an environment where you can introduce that change to children and hopefully maintain it over the course of their lives. Again, that is a longer-term result, but that is where you make the impact.

To pick up on the smoking aspect, in a past life, I was the tobacco control lead for Angus, and vaping is so much more prevalent now. We have done some work in our area with Planet Youth Scotland around children and young people who pick up vaping and are bypassing tobacco altogether and going on to other drugs. That is a challenge that we had not foreseen. We thought that vaping might be a gateway to tobacco, but that is not what has been happening. That issue is being addressed in a very local way, based on that need.

Councillor Angus-McDonald: Following on from what Julie Bell has said, I think that we need to capture momentum when we have it. As Brian Whittle rightly says, it is not necessarily about getting young people into a sport, but about getting them just to be physically active. I am not trying to preach to the Olympian, but you can see a rise in the number of people who really want to take part in sport and physical activity when the Commonwealth games or the Olympics are on and there is that momentum, but then it ebbs away.

Julie Bell was talking about that holistic approach—if we can have nice parks in local areas, and well-kept paths and routes that people can walk, it will encourage people to get out in their local environment, but if the streets are not clean, if there is litter everywhere, or if there is no street lighting, people will be less likely to do that.

We need that holistic approach, but there must also be a way of capturing and harnessing the momentum that we have when the Commonwealth games, the Olympics or the winter Olympics are on, and we need to make it as inexpensive as possible for kids to get involved,

because we know that if they get involved at a young age, they are more likely to continue.

Alastair Boyle: I totally agree with the point made by Julie Bell and Nairn Angus-McDonald that getting people at an early age and teaching them, not just about physical activity but about health and all the other areas where they can look after themselves, is enormously effective and really important. When we have visited some schools, Paul Johnston and I have been struck by the connection between the teachers and the young people; they really know where and how those young people are living their lives, and we need to put the tools in their hands so that they can provide that additional support.

Indeed, we have seen some really good work in Lanarkshire and other areas, where teaching packs and so on have been given out that are designed to help teachers who are not really sure what support they can give young people. We absolutely agree with the principle, and we want to wrap things around young people to help them form the healthy habits that will see them live longer lives.

Brian Whittle: Active schools is definitely the delivery platform—or part of the delivery platform—that works at primary and secondary school level. I would say that we do not quite have the connection yet with pre-school, and we need that to happen, especially given that most of the cardiovascular, neuromuscular and bone density mapping happens in the pre-school years.

We are talking about all the great things that are happening, and yet we have a declining healthy life expectancy. We are at the bottom of the table in Europe when it comes to health, and in the 10 years that I have been in the Parliament, we have not made any progress whatsoever in that respect. Therefore, we need a step change, and the example that I would highlight of what can happen is what has happened in Japan. They are physically active, and every school now has a nutritionist—all of that good stuff. I know that we are not Japan, and I am not saying that we should follow that approach, but what it tells us is that, where there is political will, you can make huge changes to the community. That is really where we need to be, is it not? We are just tinkering around the edges and not making progress.

Alastair Boyle: I agree, and I think that that is where the joint work that we are proposing between sportscotland and Public Health Scotland might be really valuable. Things that we are exploring in that respect include the prevention hub that Public Health Scotland has helped set up with Police Scotland and the Edinburgh futures institute, which is really good at thinking about problems and working back from them instead of just taking a principle and thinking about how to deploy it.

It is definitely an area where we are trying to get things together. We are still in the early stages—indeed, we are still to have the joint board meeting—but there is certainly scope for the two organisations to wrap around that particular problem and see what we can do.

Brian Whittle: Thank you.

The Convener: I call Emma Harper.

Emma Harper: With regard to quitting smoking, the quit your way Scotland service was established to help people stop smoking, but because of the rise of vaping—and, indeed, vaping among 12-year-olds—some challenges have arisen that might mean that quit your way will need to be adapted, or a whole separate programme put in place, for 12 to 16-year-olds. Last night, I met Dumfries and Galloway youth council members online, and one of their asks was that we do more to prevent young people vaping in the first place. However, how do we help them quit vaping, too? What work is being done to expand quit your way into vaping, and, indeed, what work is being done for 12 to 16-year-olds?

Paul Johnston: Again, we might need to follow up on some of that detail. We are certainly supporting the continued roll-out of quit your way; indeed, the most recent evaluation of it that I have seen shows that it remains highly effective as a measure against tobacco use, but we are looking at what more can be done to address the rise in youth vaping.

I just want to be clear where we are at on this. Our most recent reliable evidence is still the health behaviour in school-aged children study, which showed that 25 per cent of 15-year-olds had used a vape in the previous 30 days. We have seen a very rapid increase in that activity, and we will get a further authoritative picture of that when the next health behaviour of school-aged children study is published later this year. It is run every four years, so we do not yet know what sort of trend we are going to see, but we are concerned that the prevalence of vaping among young people is continuing to grow. We have absolutely supported measures to reduce vaping. For example, we have been strongly supportive of, and welcomed, the ban on disposable vapes. We think that there is a need to go further, though, and to put in place overall frameworks to reduce and control vaping.

There is a big pillar in the Parliament's waiting area that reminds us of the action that the Scottish Parliament took on tobacco almost exactly 20 years ago. We should recognise that this Parliament has been a world leader in public health action on tobacco. There is now a need to

ask how we go further on tobacco. As a public health body, we are really anxious that there is no suggestion that the problems with tobacco have been dealt with.

10:00

We have seen some of the reductions in smoking stall, and we are still seeing very high levels of tobacco use in some of the areas of greatest deprivation in Scotland, so we are anxious that we do not take our focus away from tobacco, where the harms are absolutely proven and established. We therefore urge members in this and the next parliamentary session to get fully behind the four nations action on creating a smokefree generation through legislation. We also recognise that we need to address the growing harms of vaping, and there are packages of action to be taken to do that.

Emma Harper: Are you monitoring the use of snus? Even though it is illegal in the UK, it is obviously coming in from somewhere and young people in schools are using it.

Paul Johnston: I will check whether we are asking about that in the health behaviour in school-age children survey. I do not know offhand whether we are asking specific questions about it. We are asking about vaping. I will check whether we cover a wider range of products and get back to you on that.

Sandesh Gulhane (Glasgow) (Con): I will pick up on what was said earlier about the opportunities that we have to get kids into sport when the Olympics or other big sporting events are on. The Commonwealth games are coming to Glasgow, yet the evidence that we took previously is that there will be absolutely no legacy from those games. What should we be doing to really capture the Commonwealth games in Glasgow—they will be a resounding success—and get kids more involved in sport? Ultimately, some of the world's top athletes will be coming to compete and to inspire us all.

Alastair Boyle: That is a great question. For a start, I absolutely agree that the Commonwealth games will be a success. Secondly, I agree that there is a huge opportunity there and we cannot let it go to waste. At Public Health Scotland, we want to be seen as a delivery organisation, but we are often not the deliverers, so it is about how we can influence and how we can stand beside people. It is for us to think about the body of evidence that we have just discussed on the difference that physical activity can make to people, including in relation to social aspects and a Scotland where everyone can thrive. We then need to think about how we can use that to influence our partners.

As I said, I am quite excited about the joint working that we are going to do with sportscotland—there are real opportunities there. I know that sportscotland is particularly focused on that area, so it is probably better placed to answer the question than I am, but it is certainly an area that we will be working on together. We absolutely agree that it is an opportunity that we must take maximum advantage of.

Paul Johnston: There is some additional funding going into sport this year, and I hear what members of the committee have said about the importance of sport and physical activity. I absolutely agree with that. I am very happy to take this back to colleagues in Public Health Scotland, who are working on these issues, to ask them what more we can do, including this year and this summer, working with our community planning partners and with sports clubs to see how we can maximise the positive opportunities that the games bring.

Gillian Mackay (Central Scotland) (Green): Building on what we have already been talking about, I want to cover some of the issues around the social determinants of health. The panel has already recognised that many of the drivers lie outside the public health sphere or even the health policy sphere. How is Public Health Scotland breaking out of that and working across portfolios within Government and local government?

Alastair Boyle: That is a great question. The area feels quite familiar to me, as I spent 20 years in the Scottish Fire and Rescue Service trying to deliver prevention where the levers of influence were not ours, but lay elsewhere. The Fire and Rescue Service and other organisations, including Public Health Scotland, have shown that, when we put the right people and the right ideas together, supported by the evidence, we can make an enormous difference.

As an organisation with the strategy that has been produced, we want to be seen, and to be felt across the system, as a delivery organisation. While we are the lead public agency tasked with protecting health, improving life expectancy and reducing the horrific inequalities that exist, we want to be the servant leaders at a local level. That means standing alongside our partners in COSLA, the community, the voluntary sector and NHS boards. We want to arm them with practical solutions.

There are things that we have developed. We co-designed and co-developed a Nesta project around using the food licensing environment to make an impact on the weight of the population. There are practical examples that we can take forward.

Similarly, we are looking to see what the avenues are by which we convene people. Community planning partnerships are key. We are thinking about how we can get community planning partners together through the prevention hub and other areas, in a way that is convened around health.

We have also been considering making NHS boards population health organisations, with a maturity index to go with that. That goes from prevention being a priority all the way through to a community planning partnership. We have shared objectives that are aimed at prevention and improving the health of the population.

We are having a similar conversation with COSLA and local authorities. We are trying to create that environment. The technical bit that Paul Johnston will cover far better than I will is the Marmot principles work that we are doing in three local authority areas. We are pulling together the learning from that. We now have to consider what the next phase of that looks like. Is there stuff that we can replicate from Public Health Scotland to help people home in on the areas that would make the biggest impact? From the projects that we run, what are the practical solutions that have come out—both from the work in Scotland and from the learning from Marmot elsewhere? We have seen some interesting things in places such as Wigan, where there is a description of "Here's what we will do for you" as a system, but also "Here is our ask of the population." We are then arming people with the tools to help them live better lives, but in a way that is not accusatory or that puts the sole responsibility with them, as we discussed earlier.

There is quite a lot that we need to pull forward. For us, the opportunity from Scotland's population health framework, public sector reform and our own strategy is to make prevention an operational system, rather than just having prevention projects, so that prevention runs at the heart of everything that we do. Our challenge as an organisation—and the challenge that I have put to Paul Johnston and others—is how we influence that work. How do we ensure that we have relationships with trust, so that we are seen at a local level and the effects of our work are felt, as we stand alongside partners, identifying the areas that can make the biggest difference for citizens and then supporting them in that? It is not our job to do the work, but we absolutely have to be the catalyst that makes it happen.

Paul Johnston: We are in a good place, in that we have in place a really clear and robust framework for action that recognises exactly your point, Ms Mackay, which is that we need to take action across the whole system. No one area is unimportant and no one area will solve all Scotland's health issues. It has been interesting to see others from outside Scotland comment so positively on our population health framework. In particular, the King's Fund has written about how the framework recognises that, to improve health, we have to take action across a range of areas and shift our system to become focused on prevention.

I would hope that there will not be any moving away from the framework for action, but rather that there will be a determined cross-party effort around its implementation. Yes, that involves actions in specific areas, such as increasing physical activity and tackling obesity. Tackling obesity is recognised as a priority. The effort to implement the framework also requires us to shift our systems of public services, so that they prevent harm alongside responding to harm. That is perhaps one of the most challenging shifts that the framework sets out as necessary. We want to support that and the Parliament's role, both through its committees and as a whole, will be to hold public bodies to account. How are we spending money? How are we investing? Are we preventing harm? Are we getting upstream or are we simply in emergency and downstream responses?

That is all in the framework, which puts us in a strong position. As Ally Boyle has said, we seek to support its practical implementation, but we also recognise that a huge amount of work is ahead of us.

Gillian Mackay: My next question is for the councillors. When it comes to tackling the social determinants of health, a lot of what we need to do, in making the public environment better, lies with local authorities. Greater numbers of licences are granted for takeaways and pubs in areas of higher deprivation. At the moment, we do not support local authorities well enough to enable them to take more holistic decisions across their areas.

Licensing is one such area. I have been campaigning for a proper licensing system for vapes for quite some time now. It seems particularly topical this week. A health perspective would give teeth, as opposed to the current register, which does not provide for any consequences for people who sell vapes to children. Do the councillors believe that, in the next parliamentary session, we need to look more holistically at that—to give local authorities more back-up, and the tools to take those approaches to promoting the health of whole areas, rather than their having to look at things individually, case by case?

Councillor Bell: I have a special interest in tobacco and vaping, from a long-standing history, and I absolutely support Public Health Scotland's

ambitions for retail premises to perhaps be licensed.

My local authority does not have an overprovision policy. I have raised that on a number of occasions. It would be helpful to have support for that at national level. For example, we in PHS promote things such as minimum unit pricing for vaping—even, potentially, an industry levy. There is a whole suite of options that, if applied nationally, would support local authorities when it came to delivery. It might be that some local authorities are further down the road than others, and I think that it would help everyone to get to the same place.

On planning, Nairn Angus-McDonald touched on how our towns look and feel when it comes to community safety, particularly when it comes to women and the night-time economy but also through lots of blue and green spaces where people can connect with nature, which I find very healing. It builds pride in a community to see beautiful things that people can engage with, touch, feel, smell and hear. That makes a big difference. Given the problems of litter in some of our town and city centres, it is to be hoped that, once people start to feel that connection with the place where they live and work, they will become more engaged in looking after it. People having pride in where they live goes towards community confidence and the whole mental health and wellbeing agenda.

10:15

Councillor Angus-McDonald: I am the vice-convener of licensing in my local authority. What I have found most challenging, given that our area has some of the most deprived communities in Scotland but also some of the wealthiest, is that we are working with an antiquated licensing system. I do not seek to age anyone, but the Civic Government (Scotland) Act 1982 was enacted before I was born, and I think that I was at primary school when the most recent licensing legislation was enacted. It has not moved with the times.

An antiquated system really ties our hands in battling brand-new issues such as vapes. When it comes to overprovision, in using a system that looks purely at the Scottish index of multiple deprivation versus availability, although there is a connection, we need to be careful, as has been said, that we do not demonise people by saying, in effect, "You're in a poor community, so you can't be trusted to have an off-licence there." The licensing system needs to be updated. If that were done, it would empower licensing committees to say no.

Another issue is the fact that, although members of licensing boards and licensing committees are trained and go through tests, we are faced with lawyers who have decades' worth of experience, who tell us that, in effect, the decision that we take must be one way or another, and that we are wrong on X, Y and Z. At the moment, we have no legislative back-up to contradict that.

Gillian Mackay: That was really helpful—thank you.

Would the panel support moves to tackle certain social determinants of health? For example, vapes could be put under covers and treated in the same way as tobacco products in order to prevent what we have at the moment: massive shop fronts full of colourful, often sweetie-flavoured, vapes that tempt young people to try something in a way that they would not if it was just cigarettes that were available?

Paul Johnston: I would say yes to that proposal. We have very clear guidance on what needs to happen in relation to a range of health-harming products. The issue is about attractiveness, availability and affordability. We know what package of measures is needed, and we have applied at least some elements of that package to tobacco and alcohol. We need to take a similar approach to vaping, while ensuring that we do not take our eye off the ball when it comes to the other areas of harm, which have definitely not yet been fully addressed.

Gillian Mackay: Absolutely.

The Convener: Time is running away from us, so I ask members to keep their questions short and our witnesses to be succinct in their answers.

Emma Harper: I have some questions on the budget but, before I ask those, I have a question about junk food—ultra-high-processed food. Is it considered to be a health-harming product?

Paul Johnston: Yes—absolutely. We know that junk food contributes to obesity, which is why we have supported measures on greater regulation of—to use the umbrella term—high fat, salt and sugar foods. We are working closely with Food Standards Scotland and the Scottish Government on that. We welcome the fact that additional restrictions are scheduled to come into place in relation to the marketing of high fat, salt and sugar foods, although we think that there is a need to go further. I could say more about that, but I am mindful of the convener's request for us to be concise. I would be happy to follow up on that issue, which is a crucial area of work.

Emma Harper: That is perhaps an issue for the next parliamentary session.

Paul Johnston: I think so.

Emma Harper: About 33 per cent of the Scottish budget—£22.5 billion—is allocated to the health

and social care portfolio, £17.6 billion of which is for NHS boards. Will that level of spending help to have an impact on public health in Scotland?

Paul Johnston: As you say, a very large proportion of the Scottish budget is already devoted to health and social care. However, as we have discussed throughout this session, much of what has an impact on health sits outside the health system.

To answer your question, I think that we need to look at the budget in the round. Sufficient funding needs to be provided for the health system, but sufficient funding also needs to be provided for local government and the third sector, given the crucial role that they play in supporting health and wellbeing. We have not really touched on the third sector's role.

From our perspective in public health, we want to ensure that the health service is increasingly focused on preventing harm. If we do that, we should be able to stop there being so much pressure on increasing health service budgets.

We have supported recent work by the Scottish Fiscal Commission that deals with exactly this point. The Fiscal Commission's report in 2025 looks at the relationship between funding and health, and it shows that, if Scotland's health continues to underperform compared with the health of the rest of the UK, over the coming decades, we face huge fiscal pressures. By contrast, if we can have focused system-wide action to improve Scotland's health, and if it can match or better that of the rest of the UK, we will start to see the fiscal headroom that we need to properly invest in public services.

I would absolutely commend the work of the Scottish Fiscal Commission in its health and economy report, which we contributed to.

Alastair Boyle: Paul Johnston makes an extremely important point, which is that it is not about what the budget is, it is about where it is spent. We are working with colleagues in NHS boards across the country on how we can start to see that spend tagged, so that we can track how much money is being spent in prevention. We are working with the Government on that.

One of the most important points in the Scottish Fiscal Commission report is that not only will the response spend have to increase, it will eat into areas such as education, benefits and local authority spend, and a lot of that could be preventative in nature. By not preventing, you are further eating into our ability to prevent and making it even harder for us to get to make progress in the future.

Emma Harper: Are there challenges with the prevention budget competing with acute services? Are we always firefighting at the front door of accident and emergency, for instance?

Alastair Boyle: Yes. There is no doubt that there is a challenge around that, because we must respond to and take care of the people who are there, which naturally takes up quite a proportion of the budget just now. However, through conversations with colleagues across Scotland and in the board chairs group and the new subnational planning structures, we have heard quite a clear direction from the Scottish Government and from the director general for health and social care that prevention should run alongside all the work that we are doing to make the NHS in Scotland more efficient, and to plan on a population basis rather than just on the basis of boundaries. Right up the middle of that work has to be reducing inequalities and driving towards prevention.

As I said before, our job now is to make that feel practical and to give examples of where we have, on a once-for-Scotland basis, done the evaluation, established what works, taken the learning from elsewhere and then put it in the hands of people who can then deploy that approach in order to make a difference.

Emma Harper: I have a final question. Julie Bell, you mentioned housing. Do you agree that it is not just about the health portfolio and the health budget; it is about everything that must be inputted, and housing would be part of that?

Councillor Bell: Yes, 100 per cent—and it means having appropriate housing as well.

Prevention means different things to different parts of the system. If you are looking at delayed discharges in an acute setting, and someone does not have somewhere suitable to move to—perhaps their previous house is on the third floor and they do not have the mobility to get there—they have to wait for a suitable place to live. That absolutely mirrors my caseload as a local authority councillor. I get issues like that coming up regularly. Someone will ask, "Why is my dad still in hospital when he has been assessed as being fit to come home?" The answer is that his current house is not suitable and there are limited options when it comes to where he could move to. That is why there is a challenge around delayed discharges.

In Angus, we do quite well on the delayed discharge front, so we could replicate that across the country. There is an impact on the individual and their immediate family as well as on the system. We want there to be a greater opportunity to look after a person at home, because that is in their best interest. It is about their quality of life, but there is also a positive impact on the cost to the health service.

I used to sit on a territorial board as well, and I absolutely appreciate the challenges that boards have with regard to diverting resources to prevention spend when they are very busy dealing with the pressing needs of individuals. Providing the evidence for the value of that preventative spend is one of the things that Public Health Scotland can bring to the table

Carol Mochan (South Scotland) (Lab): People have already answered some of the questions that I was going to ask, and I know that we are tight for time, but I was also going to ask about the actions of the Parliament in the coming session. Councillor Nairn Angus-McDonald appropriately picked up that delivery is a matter for local government, but what legislation could the Parliament pass in the next session that might help to move the dial? You are basically saying, "We know what to do—we need to move the dial."

Paul Johnston: We have given that a great deal of thought, and that has informed the policy briefing, which has been included in the papers for today's meeting. The briefing sets out specific proposals for legislation and other action by the Scottish Parliament. We think that there is both a need and real scope for specific action on food and the food environment. I would start there. Alastair Boyle mentioned that we have been working closely with the think tank Nesta. I would commend to members Nesta's report on tackling obesity, which gives cause for optimism that, through close engagement with the food industry and food retailers, and through the use of targeted legislation, it is possible to transform the food environment in Scotland in a way that enables us all to live a healthier life but has particular benefits for those who are currently facing the greatest areas of disadvantage. It seems to us that there is growing momentum around those issues and growing public will for action. In the briefing, we refer to some of the surveys that have been done to gauge public appetite for that, and that is one area that I would highlight for legislation.

There is also support for going further on tobacco. There may well be a need for further legislation in areas such as vaping. There is also an important area around the systems of accountability that Parliament has, which we refer to in the briefing. What will bodies be held to account for, and in some cases be criticised for? Is it the way in which the immediate pressures are dealt with? Is it the way in which bodies work together to support communities and to prevent harm before it occurs? That whole area of accountability, it seems to us, is one of the crucial areas for the next Parliament to grasp.

Carol Mochan: Councillor Angus-McDonald, given that you spoke about local government, is there something specific that the Parliament needs to do to support it?

Councillor Angus-McDonald: Unsurprisingly as a councillor, I think that there is always a need for funding. If the Parliament wants to have targeted early intervention and prevention spend, it needs to consider whether specific funds can be ring fenced in addition to the block grant and the revenue grant that are given to councils. We know that we get a revenue grant and a capital grant, but perhaps we also need a prevention or early intervention grant that would allow us to spend the money where it is needed. We should consider how much of the council budget pressures that all of us in the room know about could have been alleviated if we had taken some of these issues seriously five or 10 years ago. There is a need to look at how local government is financed and whether that needs to be done on a needs basis, rather than a demographic basis. Michael Marmot speaks a lot about directing spend to where it is needed, rather than divvying it up on the basis of the population.

Sandesh Gulhane: I declare an interest as a practising NHS GP. I am glad that we have started to talk about obesity. If we are going to be honest, we need to look at how we have got here. After two decades, we are fatter and more unhealthy as a nation. Recently, our life expectancy dipped, which is unprecedented. The issue has not simply come about in the past two years; it has grown arms and legs and has got worse and worse. I heard the conversation that you have just had about the food environment. My first question is, where does personal responsibility come in?

10:30

Alastair Boyle: That is a fundamental point. I mentioned some figures earlier. While we want to create a Scotland where people can thrive, obesity is one of the things that prevents that. As well as the cost to the NHS, there is the cost to society, which we reckon is about £4 billion. It is £1 billion for responding to the demand that comes from obesity.

You are right: there has to be a balance, and we have to make it easier for people to make better choices. Then, we have to skill and support people to look after themselves. There are areas that we can explore. There is going to be a my care app. Could we get to the point of having a my health section in that app that gives people dietary information and some social prescribing, with people who can support them with physical activity? That could also help them to budget for how they cook.

There is a balance there, and those are some of the areas that we are interested in. That includes

some of the Marmot work, which uses a social contract approach, with a balance between, “This is what we will do for you,” and, “This is what we ask of you as an individual.” We have to ground that in the reality of where and how people live their lives.

At Public Health Scotland, we ensure that we are never guilty of institutional arrogance, making asks of people that put them in a position that stresses them, because they are unable to do those things or to afford them, or because it makes them feel like we are blaming them. There is a difference between blame and describing people’s responsibility. Referring to our earlier conversation, it is about grounding some of that in the early years, so that people are better skilled and able to live a healthier life.

Sandesh Gulhane: There is one thing that I think is an absolute failure of minimum unit pricing for alcohol. We are making it more expensive, but we are not really seeing a return. If you were to take away meal deals at lunch time, that would just increase the price for people. Surely we should be subsidising or improving the choice that people have to make, so that healthier choices are cheaper and more affordable. We should be making fruit and vegetables really cheap. We should be making that the obvious, best, healthiest choice that people can make and, significantly, also the cheapest.

Alastair Boyle: I would not disagree with that point about making better choices more affordable and easier for others. I am glad that you asked about minimum unit pricing. We need to have such conversations in public on the evidence and on what we are seeing.

I will let Paul Johnston talk about the detail of that.

Paul Johnston: As an organisation, we are absolutely determined to be driven and led by the evidence, and the evidence from the World Health Organization and a wide range of academic sources is clear: that we need to tackle the availability, affordability and attractiveness of health-harming products. We will stand by our evaluation of minimum unit pricing, which the Parliament has considered carefully. We are very clear that it has resulted in reduced hospitalisations and has contributed to—

Sandesh Gulhane: Was that statistically significant?

Paul Johnston: We are clear that the reduced hospitalisations and the reduced—

Sandesh Gulhane: Sorry—that is a direct question: was that statistically significant?

Paul Johnston: I will follow up with more information on that. My understanding is that that reduction is statistically significant. Certainly, the reduction in deaths is statistically significant. I do not want to—

Sandesh Gulhane: Sorry, but was that not the theoretical reduction in deaths, rather than the actual reduction in deaths?

Paul Johnston: We have to estimate the reductions in deaths. That is clearly the case with prevention. What have we prevented? Our report included the estimated reductions in hospitalisations and deaths, done through a robust evaluation process in conjunction with a number of academic partners, which was widely reported. I am happy to say more about that.

The point is that the learning from minimum unit pricing for alcohol can be applied to other areas of harm, including obesity.

At no point have we suggested that simply increasing the price of alcohol is a sufficient measure to tackle harm from alcohol, and personal choice has a role to play. We need a suite of actions that the evidence points to as effective, so let us translate that into the territory of tackling obesity. That is why we would say that there is a need for action on foods that are high in fat, salt and sugar. There is a need for action by the Parliament to ensure that unhealthy options are not the ones that are most heavily discounted or the ones that are promoted in everybody’s face when they walk into a supermarket. However, I absolutely agree with the point just made that we also want to support the healthy choices being the ones that are discounted, more affordable and more readily accessible. That draws on robust evidence on the range of measures that need to be taken to address these health harms.

Sandesh Gulhane: It is always easy to raise the price of things. That is the stick, but the carrot never follows. The only action that we have taken on alcohol is minimum unit pricing—that is it; that is the magic bullet—and I strongly disagree with the findings that you have spoken about. It is a completely different topic.

I want to touch on glucagon-like peptide-1 receptor agonists. What is the current evidence, and do you think that we need a serious conversation about rolling out their use much more broadly to tackle obesity? Going back decades, people have always said, “Oh, just give me a pill and help me lose weight”, so that is what we have got. Nothing is free in healthcare; everything has a risk, a side effect and a cost, but is this approach worth while, and should we hold on to get the pills that are potentially coming to try to reduce weight?

Paul Johnston: GLP-1s are an important topic, and I am sure that the Parliament will, rightly, get into in some detail on that in the next session.

With Scotland's directors of public health, we published a position statement on tackling obesity, which largely focused on what we have been talking about in relation to the food environment and the way that food is sold. It dealt with the need for physical activity as a vital way to improve health.

The statement also recognised that we are seeing a suite of new treatments and that they have a role to play. However, as you said, there is significant cost attached to them and there is concern from a public health point of view that we could be in a situation where those with the means to afford GLP-1s can take advantage of them and others cannot, leading to the inequalities that are already associated with obesity getting worse.

Work is under way. There are already some pathways for GLP-1s to be prescribed in the NHS, and we will continue to contribute to the discussions about how access can be widened out. There is also some encouraging work that is being taken forward in the next few months in Glasgow, in partnership with the University of Glasgow and other universities, looking at the targeted provision of GLP-1s to relatively small numbers of people in the areas of greatest deprivation in Glasgow to test the impact of that approach.

This is a crucial area of public health, and I think that there is real promise in the use of GLP-1s. However, please let us not pin all our hopes on medication; we should take the preventative action that enables people to flourish and to maintain a healthy weight in the first instance. The evidence is pretty clear about some of the measures that need to be taken to secure that objective.

Sandesh Gulhane: I fully agree that, as Brian Whittle said, muscle mass is vital, as are exercising and lifting weights. Whether you are male or female, lifting weights is really good for you, especially as you get older, and will make you healthier. Along with exercising and going for walks, it is great for your mental health.

The issue is not just about taking a magic pill. In fact, I would argue that it might actually be unhealthy to simply use medication on its own, without the suite of measures around it. However, I want to focus on the GLP-1s and to pin you down on an answer. Should the Parliament in the next session ask whether the NHS should be rolling out GLP-1s for people who are categorised as being obese?

Paul Johnston: Given the way in which the evidence points to their effectiveness, and because we anticipate that the availability of the medication in tablet form will reduce the price, I think that we need to see increased use of GLP-1s. However, I cannot be definitive about the criteria that should be applied to their use in Scotland's NHS. We will contribute to that discussion, which will require separate consideration of governance and affordability. I agree that it is important for the next Parliament to address the issue.

The Convener: The Scottish national audit programme—SNAP—is run by Public Health Scotland. How many audits are carried out into treatment for mental illness?

Paul Johnston: We have one particular audit programme in relation to treatment for mental illness. I do not have details of all the audits with me, but I can provide the committee with information about the whole suite of audits that we carry out.

The Convener: The vision for SNAP is

"to provide an internationally recognised health intelligence service which, by working in partnership with stakeholders to audit clinical care, plays a key role in promoting safe, effective and person-centred healthcare in Scotland."

How does that vision align with the decision to step back from the Scottish electroconvulsive therapy audit network, more commonly known as SEAN?

Paul Johnston: Thank you for bringing up the issue, convener. I can confirm that we have not taken a final decision on stepping back from that audit.

My colleagues in Public Health Scotland have looked at the range of audits and at which of those audits have the greatest impact in improving health, and they have set out a proposal to step back from that specific audit and to work closely with Healthcare Improvement Scotland. I am well aware of the representations that have been made expressing concern about that, and I can confirm that we are looking closely at them before a final decision is made.

We will engage this week with relevant clinicians in that area, and I am happy to provide further information about the outcome of the process.

The Convener: That would be really helpful, Mr Johnston, because the clinical steering group raised serious concerns and was informed that the step back from SEAN would be effective from 1 April, which is less than 20 days away.

Given that it has been acknowledged that the network plays a crucial role in benchmarking ECT standards and driving forward measurable improvements in clinical practice, the steering group has huge concerns about the decision. You are now telling me that there has not been a

decision, and I will take you at your word. I would be grateful if you could write to the committee about the outcome of those discussions.

I was also going to ask you about any impact assessments that had been carried out in making the decision, so perhaps you could also write to the committee about that.

Paul Johnston: I am happy to do so. I have seen a fairly detailed consideration of the proposal, which is based on the possible impact of stepping back, but, as I said, no decision has been made. I will be in further discussion about that this week and will ensure that we write to the committee to confirm where we get to.

The Convener: Brian Whittle has a final question.

Brian Whittle: I have a quick point about MUP. My worry is that it does not happen in a vacuum, and I am concerned that there might be a correlation between MUP and the hugely disproportionate rise in the use of street benzos in Scottish index of multiple deprivation 1 areas in Scotland. We need to look at that.

Here is my question. Far be it from me to stop talking about sport, the Commonwealth games or the Olympics, but the biggest impact that we could have on long-term health in Scotland would come from what we do in the early years and how we introduce active play and a far better diet for children in that age group.

I will finish on this question: where are we with that? We have the opportunity through the 1,140 hours to make a huge impact on that age group, and that would be the biggest impact that we could have in the long term. I am struck by the fact that the kids who were in nursery when I first came into the Parliament are now teenagers in secondary school and by the impact that we could have had over that period. Where are we on the early years?

10:45

Paul Johnston: I acknowledge your point about street benzos. We have not touched on drugs in the course of this evidence session so, although we do not have time to get into it in detail, I acknowledge the huge concerns that we have about the continued high rates of drug deaths in Scotland.

I confirm that a range of work is under way in Public Health Scotland with the Scottish Government, local government and the NHS to tackle that issue. I would be happy to provide further information about it. I refer to measures such as our rapid action on drug awareness. There is a stream of work on that.

Your point on the early years is absolutely right. The first Marmot principle, which we seek to embed, is:

> "Give every child the best start in life".

Number 2 is:

> "Enable all children young people and adults to maximise their capabilities and have control over their lives".

You are absolutely right: the evidence points to the effectiveness of intervention. I am pleased that, in our focused work in North Ayrshire, South Lanarkshire and Aberdeen, real attention is being given to the earliest of years. For example, how can we ensure that we learn from some of the evidence that has emerged on the long-term impact of sure start centres as integrated models for holistic family support? That evidence, which is about the impact of providing holistic, intensive support to families who need it the most, is emerging 20 years on. That is one example.

Some of the areas that we are working in will take the learning from that and strengthen the support that is available for the earliest years.

Joe FitzPatrick (Dundee City West) (SNP): Dr Gulhane's comments about minimum unit pricing being the only thing that the Government does on alcohol were unfair. There is a range of strategies.

It would be useful for the committee if I put it on the record that, in response to a question from Elena Whitham, Maree Todd announced yesterday that she has published the new "Preventing Harm, Promoting Recovery: Scotland's Alcohol and Drugs Strategic Plan". It is probably useful for folk to have a look at that to see the range of activities that the Government and its partners—particularly in coalition with COSLA—are undertaking on those two important areas.

Paul Johnston: I confirm that Public Health Scotland has worked closely with the Scottish Government and local government on the development of that plan. As you would expect, a public health approach means that we are not saying that it is action in only one area. We recognise that we need to consider, for example, the prevention of drug and alcohol harm among children and young people. There are specific proposals on that, but we look right across the range of important areas where action is needed.

The Convener: I thank the witnesses for attending and for their evidence. I suspend the meeting to allow for a short break and the changeover of witnesses.

10:48

Meeting suspended.

10:59

On resuming—

Tobacco and Vapes Bill

The Convener: The next item is an evidence session with the Minister for Public Health and Women's Health and supporting officials on the Tobacco and Vapes Bill supplementary legislative consent memorandum, LCM-S6-51b, which was lodged in the Scottish Parliament by the Cabinet Secretary for Health and Social Care on 27 February 2026.

The legislative consent process set out in chapter 9B of standing orders requires the Scottish Government to notify the Parliament, by means of a legislative consent memorandum, whenever a UK Parliament bill includes provision on devolved matters. Each LCM is referred to a lead committee to scrutinise and report on, before the Parliament decides whether to give its consent to the UK Parliament legislating in the manner proposed.

The Tobacco and Vapes Bill was introduced in the House of Commons on 5 November 2024. The purpose of the bill is to introduce a series of measures that are described as a

"significant step in creating a smoke-free UK."

The committee has previously undertaken scrutiny of an LCM and a supplementary LCM related to the bill, and published a concluding report on that scrutiny in May last year.

On 17 February 2026, further amendments to the Tobacco and Vapes Bill were tabled in the UK Parliament that extend to Scotland, triggering the need for an additional supplementary LCM.

LCM-S6-51b sets out the Scottish Government's view that amendments grouped into four categories require the consent of the Scottish Parliament. This is because they relate to a purpose within the Parliament's legislative competence—namely public health—and because some of the amendments also alter the executive competence of the Scottish ministers. These are: various amendments that relate to filters; an amendment that relates to advertising for public health; amendments that relate to technology in devices; and an amendment that relates to liability for internet service providers.

I welcome to the committee Jenni Minto, the Minister for Public Health and Women's Health; and, from the Scottish Government, Professor Linda Bauld OBE, chief social policy adviser; Fiona Dill, team leader for tobacco and nicotine; and Katherine McGarvey, lawyer.

I invite the minister to make a brief opening statement.

The Minister for Public Health and Women's Health (Jenni Minto): Thank you, convener. Since I provided evidence to the committee on 6 May 2025, the Tobacco and Vapes Bill has continued to progress through the UK Parliament. The third reading in the House of Lords took place yesterday.

I am delighted to say that there continues to be cross-party support for the bill and for creating a tobacco-free Scotland for future generations. I am also pleased to let Parliament know that there continues to be productive and constructive engagement across the four nations over the bill's development.

The amendments that are covered in this supplementary legislative consent memorandum further strengthen the bill and are in line with the tobacco and vaping framework and the population health framework.

Today, we are focused on a second supplementary LCM that was lodged in our Parliament on 27 February. It covers amendments on filters, technology in devices, advertising for public health and liability for internet service providers.

When introduced, the bill did not cover filters. The amendments bring filters into the scope of the bill, ensuring that the legislation is as comprehensive and future proof as possible. The new powers to extend provisions in Scottish legislation to filters rest with the Scottish ministers and will be subject to the affirmative procedure, allowing appropriate scrutiny by the Scottish Parliament.

The powers that are included in the parts of the bill that cover product requirements and advertising rest with UK ministers but will require the consent of the Scottish ministers where regulations contain devolved provision. I want to assure Parliament that any future regulations on filters will be informed by consultation.

Unfortunately, the technology in vaping devices and tobacco-related devices is developing rapidly. There are now vapes that contain games, messaging capabilities or Bluetooth connectivity—features that will undoubtedly appeal to young people. The amendments on technology in devices give powers to the secretary of state to regulate technology in vaping products or tobacco-related devices, such as heated tobacco devices. There will be a requirement for the secretary of state to obtain the consent of the Scottish ministers if any future regulations contain provision that would be within the legislative competence of the Scottish Parliament.

The amendment on advertising for public health provides clarity around the intentions of the bill and

will introduce a new defence for advertising offences when a person is acting in accordance with arrangements made by a public authority. That will ensure that public authorities can enter into arrangements with businesses such as pharmacies to show materials that promote vaping or other non-medicinal nicotine products for public health campaigns. However, that does not mean that we are proposing to change our stance on vapes. Vapes are helpful to some people who wish to quit smoking and services should support people who make the choice to use a vape, but they are not without harm and they are not available via stopping smoking services in Scotland.

The intermediary liability for internet service providers amendment will ensure that there are exceptions to offences where a completely passive internet service is being provided. That applies to devolved and reserved offences. The amendment will not change the intended policy but will provide clarity on where the liability rests.

We continue to work across the four nations on the bill and officials have started to consider co-ordinated implementation plans where they are appropriate and right for Scotland. Most of the relevant enabling powers will require consultation before regulations are made. The Scottish Parliament will have the opportunity to scrutinise the content of future regulations to ensure that they meet the needs of Scottish policy.

I finish by thanking the committee for its consideration of the LCM. I recommend that the Scottish Parliament gives its consent to the amended provisions in the Tobacco and Vapes Bill.

The Convener: Thank you, minister. We now move to questions from Sandesh Gulhane

Sandesh Gulhane: I declare an interest as a practising NHS GP.

Vapes are very topical at the moment, given what has happened in Glasgow, and I put on the record my thanks to the firefighters and all the brave crews who risked their lives to keep the fire at bay. The fire started in a vape shop. Eyewitnesses suggest that it might have been caused by electrical overloading, and we certainly know that the fire started there; it was devastating. My question is about the safety of vapes, how flammable the products are—a huge number of batteries were stored in the shop, which possibly caused the popping sound we heard—and how all that might have contributed to such a devastating fire. What is the safety of vapes, and what can the minister do about it?

The Convener: Your questioning is straying quite far from the limits of the LCM. Is your question in relation to the LCM that the minister is here to speak to?

Sandesh Gulhane: Yes, I think that it is, because there is a broader question about safety when it comes to vapes and the storage of vapes—how and where they are stored—and whether the Scottish Government is perhaps able to go a little bit further to create the safety and reassurance that we all want on our high streets.

The Convener: Although I accept that those are important questions, I believe that one of your colleagues will raise them with the relevant minister in a topical question this afternoon. However, the minister who is sitting in front of the committee is here to speak to the LCM, which is quite limited in its scope. I therefore ask the minister to make some brief comments, if she can. If they relate to the LCM, that would be more appropriate.

Jenni Minto: I was also concerned and saddened having seen the coverage of the fire unfolding on Sunday, the devastation that it has caused to businesses and the disruption that it will cause to those travelling into and around Glasgow city centre. It is essential that the Scottish Fire and Rescue Service is now able to undertake full investigations with its multi-agency partners to understand the nature of the fire and why it spread as it did. It is inappropriate for me to comment further at this stage, but I want to be clear that we will consider the issues around the fire with an open mind, and, as the convener indicated, a topical question on the matter will be taken in the chamber this afternoon.

The Convener: Sandesh, do you have any further questions?

Sandesh Gulhane: Yes I do. Minister, you said that your position has not changed when it comes to vapes due to their use in helping people to quit smoking. Although vapes are a valuable aid in that respect, less than 6 per cent of the population would be affected by the policy on vapes, and that percentage will be even lower for people who are actively trying to quit smoking.

Vaping is on the rise, especially among children. Why has the position not changed, given that vaping affects such a small proportion of the population? Should we consider doing more to prevent vapes from getting into the hands of children and from being so prevalent? As we heard in the previous evidence session, people are simply starting to vape and skipping all the other steps, and are perhaps using vapes as a gateway into other drugs.

The Convener: Again, minister, please make your comments in relation to the LCM that is in front of us.

Jenni Minto: As Dr Gulhane has indicated, the Scottish Government's policy with regard to vapes has not changed. Vapes are one of a range of tools that smokers can choose to help them quit. We are clear that we do not believe that vapes are appropriate for non-smokers. However, the amendment that is in the LCM will ensure that, if the policy changes in the future, we can use the bill as needed to ensure that, if the view from a public health perspective is that vapes are a suitable tool for ceasing smoking, that can occur. Therefore, it is an important amendment.

Sandesh Gulhane: Okay, thank you.

Emma Harper: Good morning. This legislation is about tobacco and vapes. There is a rise in vaping among young people, but there are also issues about snus products being taken. It is not illegal to possess snus in the UK but it is illegal to sell it. Does the bill—

The Convener: Again, Ms Harper, the minister is here in relation to the LCM. Please keep your questions in relation to the LCM.

Emma Harper: My simple question is this: does the LCM not cover snus, and would further legislation be needed to incorporate that?

Jenni Minto: As you pointed out, those products are not currently captured by regulation on tobacco or vapes in the UK. As such, they are regulated only under general consumer product safety regulations. That means that there are currently no restrictions on the nicotine content. If it is passed, the Tobacco and Vapes Bill will introduce a range of restrictions, including on the age of sale, advertising, free distribution and retail register for the products. However, there would clearly be consultation on that.

Emma Harper: Thanks.

Gillian Mackay: Given the range of powers that are in the bill and how far it will stray into devolved competence, and given that, so far, nothing has been done to tackle vapes on a cross-UK basis, what room will the bill leave for Scotland to be able to take targeted measures, rather than needing to wait for targeted measures to be introduced across the UK?

Jenni Minto: Where we believe that elements of the bill will come into devolved competencies—and public health is a devolved competency—we would do the necessary work on that, probably along with Public Health Scotland, which has just been speaking and giving evidence to you. We would be able to do that under devolved competencies.

Gillian Mackay: Thank you.

The Convener: I thank the minister and her officials for attending the meeting this morning.

As is currently planned, this will be the final meeting of the Health, Social Care and Sport Committee in this parliamentary session. I take this opportunity to thank all those who have engaged with the committee and contributed to its work programme over the course of session 6. I also thank my fellow committee members for their constructive and collaborative contributions over the course of the session.

11:14

Meeting continued in private until 11:33.

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